Georgia Department of Human Resources

NOTICE OF DENIAL, TERMINATION, OR REDUCTION IN SERVICE FROM THE COMMUNITY CARE SERVICES PROGRAM, FORM 5382

To_____ Date _____

_____

_____

Your participation in the Community Care Services Program (CCSP) has been given careful consideration. In accordance with the Code of Federal Regulations, 42 CFR 431 subpart E, the following determination has been made:

A. You have been determined ineligible for Community Care Services because

_____

_____

B. You have been determined no longer eligible for Community Care Services because

_____

_____

C. You have been determined to require fewer services because

_____

_____

If for any reason, you think the proper consideration has not been given to your situation, or if you disagree with this decision, you have the right to a hearing conducted by the Office of State Administrative Hearings. You may request a hearing orally or in writing by notifying the Area Agency on Aging or the care coordination agency listed at the bottom of this letter within 30 days of the date of this form. If you want a hearing, call your Area Agency on Aging or care coordination agency or send your written request to the address listed below. If you are currently receiving Community Care Services and have been sent a notice advising termination or reduction of services, you must request a hearing within 10 days of the date of this form to continue receiving service at the current level. If you are appealing a denial, you must wait for the Office of State Administrative Hearings to conduct a hearing and rule in your favor before you can receive Community Care Services.

If you request a hearing within the time frames stated above, it will be held in your county by an Administrative Law Judge employed by the Office of State Administrative Hearings.

You have the right to be represented at such hearing by a legal representative, friend, or other spokesperson. Contact the person indicated below for information about legal services which may be available in your community without cost to you.

_____ (____)_____

Screening Specialist/Care Coordinator Telephone

AAA or care coordination agency address:

_____

_____

_____

_____

Instructions
Community Care Services Program

NOTICE OF DENIAL, TERMINATION, OR REDUCTION IN SERVICE
FORM 5382

Purpose: This form is used to notify applicant/client of CCSP eligibility status or service reduction.

NOTE: Do not use this form to notify a client of a Level of Care denial or termination.

Who Completes/When Completed: The telephone screening specialist or care coordinator completes this form to advise a client of adverse action.

Instructions:

To: Enter name and address of the person to whom correspondence is being mailed.

Date: Enter date correspondence is mailed.

A. Enter the reason why applicant is not eligible for CCSP. Indicate which eligibility criteria are not met. Enter the reason for denial.

B. Complete this section when client is no longer eligible for any other reason other than level of care. Indicate which eligibility criteria are not met. Enter the reason for termination.

C. Complete this section when client is determined to be eligible for fewer services or units of service than s/he is currently receiving.

NOTE: Form 5382 is not mailed to client when Utilization Review determines a client is inappropriate or reduces or terminates service.

Screening specialist or care coordinator completing the form signs on appropriate line.

Telephone: Enter area code and telephone number of screening specialist or care coordinator completing form.

Distribution: Original is mailed to the client. Copy is filed in case record.

NOTICE OF RIGHT TO APPEAL DECISIONS REGARDING
COMMUNITY CARE SERVICES PROGRAM, FORM 5381

_____ _____
Client's Name Date

As an applicant for services or an individual receiving services through the Community Care Services Program (CCSP), you have the right to appeal any decision with which you disagree in regard to your participation in the Community Care Services Program. If you are receiving services, any or all services may change due to any of several reasons. If you disagree with a decision to change your current services or feel that a mistake has been made with regard to the services you are receiving in the Community Care Services Program, you have the right to a hearing.

You may request a hearing either orally or in writing within thirty (30) days of the adverse action by notifying the care coordinator, whose address and telephone number are at the bottom of this letter. If you are currently receiving Medicaid services under the CCSP and wish them to continue at the current level, you must request a hearing within ten (10) days of the date of the letter you receive advising you of the decision. The hearing will be held in your county by an Administrative Law Judge from the Office of State Administrative Hearings. The care coordinator will be available to provide the necessary forms and to assist you in preparing for the hearing.

You have the right to be represented at your hearing by an attorney, a relative or friend, or other spokesperson. Contact the care coordinator for information about legal services which may be available in your community without cost to you.

Care Coordinator _____
Telephone Number (_____) _____
Address _____

_____

_____

Form 5381, Rev. 7/2002

Instructions
Community Care Services Program

NOTICE OF RIGHT TO APPEAL DECISIONS REGARDING CCSP, FORM 5381

Purpose: Form 5381 is used to advise client at the initial face-to-face assessment of the right to appeal any adverse action decision.

Who Completes/When Completed: The RN completes this form.

Instructions:

Enter client's name.

Enter date the form is mailed or given to client.

Enter care coordinator's name, telephone and address of the care coordination agency.

Distribution: During the initial assessment, the original is given to client. A copy is filed in the client's case record.

OSAH FORM 1

This form is available online at http://www.ganet.org/osah/form.html or by telephone request at (404)657-2800.

OSAH USE ONLY DOCKET NO:	AGENCY CODE AGING	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE

NAME OF REFERRING AGENCY: **DIVISION OF AGING (AGING) -DEPARTMENT OF HUMAN RESOURCES**

Use ONLY For COMMUNITY CARE SERVICE PROGRAM Cases

SELECT ONE CASE TYPE:

☐ **CCSP-SERV-(Community Care Services Program -- Services)**
☐ **CCSP-ELIG– (Community Care Services Program – Eligibility)**

COUNTY OF NON-AGENCY PARTY'S RESIDENCE:

DATE OF REQUEST FOR HEARING:

CONTACT PERSON IN REFERRING AGENCY and ATTORNEY:

NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	POSITION	EMAIL PAGER
ATTORNEY NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	GEORGIA BAR NO	EMAIL PAGER

NON-AGENCY PARTY and ATTORNEY

NAME OF EMPLOYEE	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE ON HEARING REQUEST		EMAIL PAGER
ATTORNEY NAME	TEL NO	FAX NO
CURRENT ADDRESS INCLUDING ZIP CODE	GEORGIA BAR NO	EMAIL PAGER

FOR PURPOSES OF THIS HEARING, The PETITIONER will be the ☐ REFERRING AGENCY ☐ NON-REFERRING AGENCY PARTY
(check one)

DOCUMENT INITIATING THE HEARING: ☐ As "Attachment 1" to this form, attach the document initiating the hearing.
ISSUES TO BE RESOLVED: ☐ As "Attachment 2", attach an outline of the legal issues and factual matters to be resolved at the hearing including specific statutes or rules to be applied at the hearing
SPECIAL REQUIREMENTS: ☐ As "Attachment 3", attach a sheet identifying any statutes or rules (state or federal) establishing any specific time deadlines or procedures that are to be applied by OSAH in resolving the matter referred.
SERVICE OF DOCUMENTS: In addition to routine service on the agency's attorney, the agency contact person requests the following:

☐ No service of documents prior to certification of the file to the agency after a decision.
☐ Service of all documents prior to certification of the file to the agency after a decision.
☐ Service of a copy of the notice of hearing.
☐ Service of a copy of a continuance.
☐ Service of copy of any interim orders.

All documents will be mailed to the referring agency at the address indicated for the contact person to the contact person's attention unless written instructions provide an alternative place for service.

Instructions
Community Care Services Program

OSAH FORM 1

Purpose: This form is used as a cover letter for CCSP appeals submitted to Legal Services Office (LSO).

Who Completes/When Completed: AAA staff and care coordinators complete this form when submitting appeals from applicants and participants in the CCSP.

1. Indicate the name of the AAA or care coordination agency as the referring agency.
2. Write the client's name in the section used for the name of the employee.

Distribution: The original is used as the cover sheet to the appeal packet of information submitted to LSO and a copy is filed in the client's case record with a copy of the appeal packet.

Determine Your Nutritional Health

The Warning Signs of poor nutritional health are often overlooked. Use this checklist to find out if you or someone you know is at nutritional risk.

Read the statements below. Add up the numbers in the "YES" column for those that apply for you.

	YES
I have an illness or condition that made me change the kind and / or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits or vegetables, or milk products.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 2 or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and / or feed myself.	2
Total	

Total your Nutritional Score: If it's-

0-2 **GOOD!** Recheck your nutritional score in 6 months

3-5 **You are at Moderate nutritional risk.** See what can be done to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center or health department can help. Check your score again in 3 months

6 or more **You are at high nutritional risk** Bring this checklist the next time you see your doctor, dietitian or other qualified health or social service professional. Talk to them about any problems you may have. Ask for help to improve your nutritional health.

Remember that Warning Signs suggest risk, but do not represent a diagnosis of any condition. Turn to the page to learn more about the Warning Signs of poor nutritional health.

The Nutrition Checklist is based on the Warning Signs described below.
Use the word DETERMINE to remind you of the Warning Signs.

Disease

Any disease, illness or chronic condition which causes you to change the way you eat, or makes it hard for you to eat, puts your nutritional health at risk. Four out of five adults have chronic diseases that are affected by diet. Confusion or memory loss that keeps getting worse is estimated to affect one out of five or more older adults. This can make it hard to remember what, when or if you've eaten. Feeling sad or depressed, which happens to about one in eight older adults, can cause big changes in appetite, digestion, energy level, weight and well-being.

Eating Poorly

Eating too little and eating too much both lead to poor health. Eating the same foods day after day or not eating fruits and vegetables, and milk products daily will also cause poor nutritional health. One in five adults skip meals daily. Only 13% of adults eat the minimum amount of fruits and vegetables needed. One in four older adults drink too much alcohol. Many health problems become worse if you drink more than one or two alcoholic beverages per day.

Tooth Loss/Mouth Pain

A healthy mouth, teeth and gums are needed to eat. Missing, loose, or rotten teeth or dentures which don't fit well or cause mouth sores make it hard to eat.

Economic Hardship

As many as 40% of older Americans have incomes of less than $6,000 per year. Having less -- or chosing to spend less -- than $25-30 per week for food makes it very hard to get the foods you need to stay healthy.

Reduced Social Contact

One-third of all older people live alone. Being with people daily has a positive effect on morale, well-being and eating.

Multiple Medicines

Many older Americans must take medicines for health problems. Almost half of older Americans take multiple medicines daily. Growing old may change the way we respond to drugs. The more medicines you take, the greater the chance for side effects such as increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea, nausea, and others. Vitamins or minerals when taken in large doses act like drugs and can cause harm. Alert your doctor to everything you take.

Involuntary Weight Loss/Gain

Losing or gaining a lot of weight when you are not trying to do so is an important warning sign that must not be ignored. Being overweight also increases your chance of poor health.

Needs Assistance to Self Care

Although most older people are able to eat, one of every five have trouble walking, shopping, buying and cooking food, especially as they get older.

Elder Years Above Age 80

Most older people lead full and productive lives. But as age increases, risk of frailty and health problems increase. Checking your nutritional health regularly makes good sense.

Reprinted with permission from the Nutrition Screening Initiative, a project of the American Academy of Family Physicians, the American Dietetic Association and the National Council on the Aging, Inc., and funded in part by a grant from Ross Products Division, Abbott Laboratories.

Instructions

Community Care Services Program

NUTRITIONAL SCREENING INITIATIVE (NSI) NUTRITIONAL HEALTH CHECKLIST

Purpose: The purpose of the NSI Checklist is to identify individuals who are at high risk of nutritional problems or who have poor nutritional status.

Who Completes/ When Completed: The care coordinator does not use the NSI checklist when completing an assessment or reassessment; instead, the RN or care coordinator completes the NSI in CHAT. Based on the client's score the NSI checklist may be completed between assessments.

NOTE: Referral sources include but are not limited to physicians, dietitians or other health professionals, social services, oral health, mental health, nutrition education, support or counseling services.

Instructions:

For each of the ten statements, read and circle the appropriate number in the "Yes" column which describes each client/ client representative response. Total the numbers circled to identify the client's nutritional score.

Based on the total score, make the appropriate referrals, if indicated, as suggested in the reference - Nutrition Interventions Manual for Professionals Caring for Older Americans Executive Summary 1992. Document all activity relative to the NSI checklist referral, such as follow-up and outcome results. Complete the NSI checklist as needed.

Distribution: A copy is filed in the client's case record along with documentation regarding any deviation from normal, specific instructions or referral information.

Community Care Services Program

POTENTIAL CCSP MEDICAID MAO FINANCIAL WORKSHEET

Client's name _____ Date of birth _____

Section I. INCOME	AMOUNT
Social Security	$_____
VA benefits	$_____
Retirement/Pension	$_____
Interest/Dividends	$_____
Other (specify)	$_____
TOTAL INCOME	$_____

NOTE: If monthly income exceeds the limit, stop here

Section II. RESOURCES	ESTIMATED VALUE
Cash	$_____
Checking account	$_____
Savings account	$_____
Credit Union account	$_____
Certificate of Deposit or IRA $_____	
Stocks or bonds	$_____
Patient fund account (held by nursing home)	$_____
House or property other than home, place that is not producing income	$_____
Other (specify)	$_____
TOTAL RESOURCES	$_____
Subtract Individual or Spousal Impoverishment Resource Limit	- $_____

NOTE: Use the Spousal Impoverishment Resource Limit when one spouse is in CCSP and the other is not in CCSP, nursing home or other institutional living arrangement.

List any resource (including home place) that has been transferred in the last 36 months:

_____

_____

_____

Section III. Statement of Intent: Cost Responsibility

I have applied for services through the Community Care Services Program. I am aware that I am responsible for the cost of services under the Community Care Services Program until the Department of Family and Children services determines my eligibility for Medicaid and cost share amount. I understand that I must apply for CCSP Medicaid benefits through the county Department of Family and Children Services (DFCS). If

DFCS determines that I have to pay a cost share, I will pay the monthly cost share to the appropriate provider(s). While waiting for DFCS to determine my cost share amount, I agree to pay to the appropriate provider(s) the full cost of services or the ESTIMATED cost share indicated on the line below, whichever the provider chooses.

$ _____

ESTIMATED COST SHARE: Based on the information provided by the client/representative, this is an estimate of the client cost share. This estimated cost share was discussed with the client/representative. They agree to apply for CCSP Medicaid at DFCS, and understand the DFCS will determine Medicaid eligibility and exact cost share amount.

If DFCS determined that I am ineligible for Medicaid, I will pay provider full cost of services.

ALL THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Client / Client Representative's signature Date

This form is not an application for Medicaid benefits. The care coordinator will advise you when to apply for Medicaid.

_____ _____

Care Coordinator Date

rev. 9/01

Instructions

Community Care Services Program

POTENTIAL CCSP MEDICAL ASSISTANCE ONLY (MAO) FINANCIAL WORKSHEET

Purpose: The Financial Worksheet is completed at the initial assessment of MAO or PMAO clients and when a change in income or resources may affect eligibility for the CCSP.

Who Completes/When Completed: The RN completes at the initial assessment. The care coordinator completes thereafter when income or resources change.

Instructions:

Section I. Income--record total income reported by client.

Section II. Resources--record client's statement of all resources based on current market value and total.

Section III. Statement of Intent: Cost share Responsibility--Explain cost share responsibility to client and include information that DFCS determines cost share amount. Give client written information about Medicaid and DFCS. Indicate the estimated cost share and discuss with client.

Distribution: Send a copy of this form to DFCS with the CCC and LOC. File the original in the client's case record.

PRIOR AUTHORIZATION REQUEST*

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
P.O. BOX 38409, ATLANTA, GEORGIA 30334

FOR DMA USE ONLY

Include This Number On All Claim Forms →

PRIOR AUTHORIZATION NO. 325303

1. Recipient Name (Last, First, Init.) | 2. Medicaid ID No.

rthdate | 4. Sex | 5. Address | Nursing Home ☐ Yes ☐ No | 6. Telephone (Area Code/Number)

7. Prescribing Physician/Practitioner Name And Address | 10. Provider Of Service(s) Name And Address

8. Medicaid Provider Number | 9. Telephone (Area Code/Number) | 11. Medicaid Provider Number | 12. Telephone (Area Code/Number)

☐ HOME HEALTH ☐ PODIATRIST ☐ OPTOMETRIST ☐ PHYSICIAN ☐ PSYCHOLOGIST ☐ DME/OP ☐ DDS ☐ PHARMACY

13. Authorization Period: From ____ Through ____ | 14. Description Of Service(s) Requested | DEPT. USE ONLY: 15. Rec. Type | 16. Ctgy. Of Svc.

17. Primary Diagnosis Requiring Service(s) | 18. ICD-9-CM

19. Justification And Circumstances For Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S)

LINE NO.	21. Description Of Procedures, Drugs, Equipment Or Other Services	22. Procedure/ Drug Code	23. Requested Or Estimated Price Per Unit	24. Bill. Units	25. Months or Units Of Service	26. Units Per Claim Max.	26. Units Per Claim Min.	27. Max. Units Per Month
2								
3								
4								
5								
6								
7								
8								

28. PROVIDER'S SIGNATURE ____ 29. DATE SUBMITTED ____

30. REQUEST: ☐ APPROVED ☐ DENIED ☐ PENDING/ADDITIONAL INFORMATION ☐ APPROVED AS AMENDED | 31. DMA SIGNATURE | 32. DATE APPROVED

33. Explanation to Provider

*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.

DMA-80 (6/84) COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER

Instructions

Community Care Services Program

PRIOR AUTHORIZATION REQUEST, DMA-80

Purpose: The DMA-80 is a request from the provider to provide client services which exceed the cost cap. All services exceeding the cost cap must by approved by the Division of Aging

Who Completes/When Completed: The care coordinator completes the DMA-80 and sends it to the Division of Services for approval. No SAF can be released to reimburse the provider for services that exceed the cost cap until the Division of Aging Services approves the request and the SAF is un pended.

NOTE: Do not send DMA-80s for MAO clients to the Division of Aging when the net amount after deducting the cost share clients does not exceed the cost limit.

Instructions:

1. Recipient name: Enter client's last name, first and middle initial exactly as it appears on Medicaid card.

2. Medicaid number: Enter client's Medicaid number exactly as it appears on Medicaid card. Medicaid number for SSI recipient is his/her social security number followed by letter "S". Medicaid number for MAO recipient does not resemble the social security number at all and ends with letter "P". Providers verify Medicaid number every month since Medicaid eligibility may change from month to month. Claims are not paid by the Division of Medical Assistance for services provided to ineligible recipients.

3. Birth date: Enter client's birth date.

4. Sex: Enter sex of client.

5. Address: Enter client's complete address.

6. Telephone number: Enter area code and telephone number of client.

7. Prescribing physician/ Practitioner name and address: Enter name and address of physician who prescribed service requested.

8. Medicaid provider number: Enter 10 digit Physician Medicaid Number. If physician is not enrolled in Medicaid program, enter his/her state license number.

9. Telephone number: Enter area code and telephone number of prescribing physician.

10. Provider of service name and address: Enter CCSP provider's agency's name and address.

11. Medicaid provider number: Enter CCSP provider's ten (10) digit provider enrollment number.
12. Telephone number: Enter area code and telephone number of CCSP provider of service(s).

13. Authorization period: Enter month for which service(s) is requested. Complete a DMA for each month requesting prior approval.

14. Description of service(s) requested: Enter type of Service(s) requested (ALS, ADH, ERS, HDM, HDS, PSS, RC).

15. **For Department Use Only:** Do not write in this space.

16. **For Department Use Only:** Do not write in this space.

17. Primary diagnosis requiring service(s): List diagnosis and describe condition briefly.

18. ICDA-8: Enter diagnosis code for International Classification of Diseases - leave blank if not known.

19. Justification and circumstances for required service(s): Enter justification of service. Justification includes he length of time cost of services is expected to exceed DHR/DMA maximum monthly amount. Explain *short term* nature of request and include descriptions of unusual or extenuating circumstances.

20. Line number: List each service on a separate line.

21. Description of procedures: List all CCSP waivered services to be reimbursed by Title XIX provided to client on separate lines, including those that are billed to a 3rd party (For example - Medicare).

22. Procedure/Drug code: Enter appropriate procedure code.

23. Requested or estimated price per unit: Enter charge per unit of service.

24. Billing unit: N/A.

25. Requested units of service: Enter number of units of procedure provided.

26. Units per claim: Use this space to calculate total cost of each service during service month.

    Enter total cost of each procedure by multiplying #23 x #25. Enter total cost of all services on Line 20-8.

27. Maximum units per month: N/A.

28. Provider's signature: Care coordinator signs form.

29. Date submitted: Enter date request is made from care coordinator's office.

FOR DIVISION OF AGING SERVICES USE ONLY

30. Request: Division of Aging staff will designate action to be taken by checking (T) one block in this section.

31. DMA signature: This section contains the signature of DHR Division of Aging Services Prior Authorization Staff.

32. Date approved: Date of approval is entered by DHR Division of Aging Services prior authorization staff.

33. Explanation to the provider: Comments from DHR Division of Aging Services prior authorization staff concerning this request are entered in this section.

Distribution: Original and all copies are forwarded to the Division of Aging Services, Upon approval, the original is maintained in the client's file at the Division of Aging Services. Three copies are mailed back to the care coordinator where the green copy is maintained in the client's case record at the PSA level and the yellow and pink copies are mailed to providers.

Community Care Services Program

PROVIDER ROTATION LOG

SSI, MAO, and PMAO Clients

SERVICE _____ **COUNTY** _____

PROVIDER NAME	PROVIDER ID NUMBER	CLIENT NAME	DATE SERVICE BROKERED	REFERRAL ACCEPTED/ DECLINED

Instructions
Community Care Services Program

PROVIDER ROTATION LOG
SSI, MAO, and PMAO Clients

Purpose: This form is used when a client does not choose a provider. New providers are added to the rotation log within three business days of the notification of the provider number from the AAA.

NOTE: There is one log, per county, per service.

Who Completes/When Completed: The care coordinator selects a provider from the top of the rotation log when the client does not select a provider. If the provider refuses to accept a client for any reason they are placed at the bottom of the rotation list for that complete rotation.

Instructions:

Service: Enter the service provided on this rotation log (e.g., Alternative Living Services, Adult Day Health).

County: Enter the county where this service is provided.

Provider Name: Enter each provider name as they are approved to provide CCSP services.

Provider ID Number: Enter each provider's ID number assigned by DMA.

Client Name: Enter the name of the client assigned to a provider by the rotation system.

Date Service Brokered: Enter the date the service was brokered and accepted by the provider.

Accepted or Declined: Enter A if the provider accepted the referral and enter D if the provider declined.

NOTE: If the provider declines the referral after accepting it, enter D and the date the referral was declined.

Distribution: This is an interoffice form and not distributed for any reason.

Georgia Department of Human Resources
Community Care Services Program

REQUEST FOR HEARING, FORM 5383

I request that the Department of Human Resources hold a fair hearing to review the adverse action taken in regard to my claim for assistance as provided under the Community Care Services Program.

The reason I want a hearing is:

_____

_____

_____

_____

Check one:

( ) I want to continue to receive CCSP services at the level that I am currently receiving.

( ) I do NOT want to continue to receive CCSP service.

_____ _____

Date Client's Signature or Mark*

_____ _____

Authorized Representative Signature of Witness*

_____

_____

Address of Witness*

* The signature and address of one (1) witness must appear above when the claimant signs with a mark (x).

Please return this completed form to your care coordinator whose address and phone number are indicated at the top of the denial, termination, or reduction in services letter from the Community Care Services Program.

FOR STATE OFFICE USE ONLY

Client's SSN: _____

Date Received: _____ Received by: _____

Date received by LSO _____

Form 5383

Instructions
Community Care Services Program

REQUEST FOR HEARING, FORM 5383

Purpose: Form 5383 is used by applicants or clients to begin the appeal process for denial, termination, or reduction in CCSP services. Clients may appeal orally with a formal written request within 15 days.

Who Completes/When Completed: The applicant/client or representative completes Form 5383 within 30 calendar days from the date of the notice of adverse action and forwards to the care coordinator or directly to the Legal Services Office.

Instructions:

The reason I want a hearing is: Client or client representative indicates reason for requesting a hearing and why s/he believes adverse action to be in error.

NOTE: Use of this form, while recommended, is optional with the client. Any written or oral request for an appeal must be accepted. A client need not state a reason for the request.

Date: Enter date request form is completed and signed.

Client's signature
or mark: Have client sign or enter his/her mark (X). If client signs by mark (X), a witness is required.

Client representative: Enter signature of client representative, if applicable.

Signature of witness: Enter signature of witness if client signs by mark (X).

Address of witness: Enter address of witness if client signs by mark (X).

Instructions

Last Update Date

DHR - Division of Aging Services
Community Care Services Program
Service Authorization Form

Print date:
Print time:

Case Manager:
Client Name: **SAF #:** **Version:**
Medicaid #: **SSN:**
Date of Birth: **County:**
Services Begin Date: **Services End:**
SAF Month: **Reason:**

Provider/ID	Procedure	Rate	Units	Amount	Net Amount

Gross Total:

Client Liability

Net Total:

Authorization and Approval

The Department of Human Resources agrees to reimburse the Department of Community Health for the State share of the services authorized above.

Case Manager: **Phone #:**

Authorizing Signature: _____ **Date:** ____/____/_____

Authorization and Approval

This service authorization has been Pended until a DMA-80 number has been approved by the Division of Aging Services

Case Manager: **Phone #:**

Instructions

Community Care Services Program

SERVICE AUTHORIZATION FORM (SAF)

Purpose: This is a printed computer form generated by AIMS after initial SAF data has been entered and for each month thereafter that services are authorized. This form is printed by the CCSP for providers to authorize reimbursement of services rendered. It is sent to the service provider and is used by the provider to obtain reimbursement from DMA's fiscal agent.

Who Completes/When Completed: Each CCSP client has a SAF for each month service is received. The care coordinator provides service information to data entry on a monthly basis or as needed basis to update AIMS.

Instructions:

Last Update Date: This is the date that the last change was made to the SAF.

Print Date/Time: This is the date/time that the SAF was generated.

Case Manager: This is the care coordinator for the client.

Client Name: This is the client's name (Last, First, Middle Initial if available).

Medicaid Number: This is the client's Medicaid number. The SAF cannot be generated without a valid Medicaid number.

Date of Birth: This is the client's date of birth as shown on Medicaid card.

Services Begin Date: This is the date the first Medicaid waivered service was provided.

SAF Month: This is the service month.

SAF #: This number is a unique identifier assigned when the SAF is generated. It is used for tracking purposes.

SSN: This is the client's social security number.

County: This is the county where the client resides.

Services End: This is the last date of service and only completed when a client is terminated.

Reason: This is the eligibility status listed in AIMS for the reason for termination.

SAF Version #:	This is a new number which is assigned consecutively every time the SAF is updated /changed with in the service month. Version numbers start over each month. It is used for tracking purposes.
Provider Name/ID:	This is the provider name and enrollment number for the authorized provider(s).
Procedure:	This is the code for the service type. See Appendix T of Part II - Provider General Manual for the service procedure codes.
Rate:	This is the service rate per unit. See Appendix T of Part II - Provider General Manual for the unit cost of services.
Units:	This is the total number units of service ordered on the Comprehensive Care Plan.
Amount:	This is the total cost per individual service calculated by AIMS.
Net Amount:	This is the change in amounts between versions.
Gross Total:	This is the total of all services authorized on the SAF.
Client Liability:	A client must be a MAO client to have a client liability.
Provider Name/ID:	This is the provider(s) that the care coordinator has determined to collect the cost share.
Amount:	This is the amount of the cost share assigned to the provider(s).
Net Amount:	Is the change in the amounts of cost share between versions.
Client Liability Total:	This is the total amount of the client liability to be collected by the provider(s).
Net Total:	This is the net amount, for which the provider may bill Medicaid after deducting the client liability.
Care Manager:	This is the care coordinator's name.
Phone #:	This is the care coordinator's phone number.
Authorizing Signature:	This is the signature of the person authorizing payment of the SAF.

Date: This is the date the SAF was authorized.

DETERMINATION OF NEED- REVISED (DON-R)

Function	Level of Impairment	Unmet Need for Care	Comments
1. Eating			
2. Bathing			
3. Grooming			
4. Dressing			
5. Transferring			
6. Continence			
7. Managing Money			
8. Telephoning			
9. Preparing Meals			
10. Laundry			
11. Housework			
12. Outside Home			
13. Routine Health			
14. Special Health			
15. Being Alone			
Total 1-6 (ADL)			
Total 7-15 (IADL)			
Total 1-15 (ADL+ IADL)			

Instructions
Community Care Services Program

TELEPHONE SCREENING

Purpose: The TS is a pre-screening tool to determine appropriateness for services based on the applicant's medical and financial status.

Who Completes/When Completed: The CCSP screening specialist completes within three business days of receiving the referral. This action may occur at the care coordination or at the AAA level.

Inform applicant of screening process before you begin.

Complete the Client Detail Report and Screening Detail found in the Client Health Assessment Tool (CHAT).

Instructions for completion of the Determination Of Need-Revised (DON-R) Functional Assessment are outlined below.

DETERMINATION OF NEED - REVISED FUNCTIONAL ASSESSMENT (DON-R)

The Determination of Need (DON) defines the factors which help determine a person's functional capacity and any unmet need for assistance in dealing with these impairments. The DON-R allows for independent assessment of both impairment in functioning on Basic Activities of Daily Living (BADL) and Instrumental Activities of Daily Living (IADL) and the need for assistance to compensate for these impairments.

Assess both Column A Level of Impairment, and Column B Unmet Need for Care on all applicants. A minimum score of 15 is required in Column A Level of Impairment along with identified Unmet Need for Care in Column B, before a client is referred to care coordination for assessment. If the Level of Impairment score is less than 15 refer client for HCBS or other available resources.

The central question to determining the level of need for care is whether a person can perform activities of daily living (ADL). Table 1 presents the list of ADL included in the DON under two headings: BASIC AND INSTRUMENTAL.

Table 1 - Activities of Daily Living Included in the Determination of Need (DON) Functional Assessment

BASIC ACTIVITIES OF DAILY LIVING (BADL)	INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)
Eating	Managing Money
Bathing	Telephone

Grooming	Preparing Meals
Dressing	Laundry
Transfer (In and Out of Bed/Chair)	Housework
Bowel/Bladder Continence	Outside Home
	Routine Health
	Special Health
	Being Alone

ITEM DEFINITIONS

1. EATING:

A. Is the client able to feed himself/herself?

Assess the client's ability to feed oneself a meal using routine or adapted table utensils and without frequent spills. Include the client's ability to chew, swallow, cut food into manageable size pieces, and to chew and swallow hot and cold foods/beverages. When a special diet is needed, do not consider the preparation of the special diet when scoring this item (see "preparing meals" and "routine health" items).

B. Is someone available to assist the client at mealtimes?

If the client scores at least (1) in Column A, evaluate whether someone (including telephone reassurance) is available to assist or motivate the client in eating.

2. BATHING

A. Is the client able to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene as needed for the client's circumstances?

Assess the client's ability to shower or bathe or take sponge baths for the purpose of maintaining adequate hygiene. Consider minimum hygiene standards, medical prescription, or health related considerations such as incontinence, skin ulcer, lesions, and frequent profuse nose bleeds. Consider ability to get in and out of the tub or shower, to turn faucets, regulate water temperature, wash and dry fully. Include douches if required by impairment.

B. Is someone available to assist or supervise the client in bathing?

If the client scores at least (1) in Column A, evaluate the continued availability of resources to assist in bathing. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

3. GROOMING

A. Is the client able to take care of his/her personal appearance?

Assess client's ability to take care of personal appearance, grooming, and hygiene activities. Only consider shaving, nail care, hair care, and dental hygiene.

B. Is someone available to assist the client in personal grooming tasks?

If the client scores at least (1) in Column A, evaluate the continued personal assistance needed, including health professionals, to assist client in grooming.

4. DRESSING

A. Is the client able to dress and undress as necessary to carry out other activities of daily living?

Assess the client's ability to dress and undress as necessary to carry out the client's activities of daily living in terms of appropriate dress for weather and street attire as needed. Also include ability to put on prostheses or assistive devices. Consider fine motor coordination for buttons and zippers, and strength for undergarments or winter coat. Do not include style or color coordination.

B. Is someone available to assist the client in dressing and undressing?

If someone scores at least one (1) in Column A, evaluate whether someone is available to help dressing and/or undressing the client at the times needed by the client. If intimate assistance is available but inappropriate and/or opposed by the client, consider the assistance unavailable.

5. TRANSFER

A. Is the client able to get into and out of bed or other usual sleeping place?

Assess the client's ability to get into and out of bed or other usual sleeping place, including pallet or armchair. Include the ability to reach assistive devices and appliances necessary to ambulate, and the ability to transfer (from/to) between bed and wheelchair, walker, etc. Include ability to adjust the bed or place/remove handrails, if applicable and necessary. When scoring, do not consider putting on prostheses or assistive devices.

B. Is someone available to assist or motivate the client to get in and out of bed?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, (including telephone reassurance and friendly visiting) to assist or motivate the client in getting into and out of bed.

6. CONTINENCE

A. Is the client able to take care of bladder/bowel functions without difficulty?

Assess the client's ability to take care of bladder/bowel functions by reaching the bathroom or other appropriate facility in a timely manner. Consider the need for reminders.

B. Is someone available to assist the client in performing bladder/bowel functions?

If the client scores at least (1) in Column A, evaluate whether someone is available to assist or remind the client as needed in bladder/bowel functions.

NOTE: When using the MDS-HC, the DON question regarding continence is incorporated in the MDS-HC question for toilet use.

7. MANAGING MONEY

A. Assess the client's ability to handle money and pay bills. Include ability to plan, budget, write checks or money orders, exchange currency, and handle paper work and coins. Include the ability to read, write and count sufficiently to perform the activity. Do not increase score based on insufficient funds.

C. Is someone available to help the client with money management and money transactions?

If the client scores at least (1) in Column A, evaluate whether an appropriate person is available to plan and budget or make deposits and payments on behalf of the client. Consider automatic deposits, banking by mail, etc.

8. TELEPHONING

A. Is the client able to use the telephone to communicate essential needs?

Assess the client's ability to use a telephone to communicate essential needs. The client must be able to use the phone: answer, dial, articulate and comprehend. If the client uses special adaptive telephone equipment, score the client based on the ability to perform this activity with that equipment. Do not consider the absence of a telephone in the client's home. (Note: the use of an emergency response system device should not be considered.

B. Is some available to assist the client with telephone use?

If the client scores at least (1) in Column A, evaluate whether someone is available to help the client reach and use the telephone or whether someone is available to use the telephone on behalf of the client. Consider the reliability and the availability of neighbors to accept essential routine calls and to call authorities in an emergency.

9. PREPARING MEALS

A. Is the client able to prepare hot and/or cold meals that are nutritionally balanced or therapeutic, as necessary, which the client can eat?

Assess the client's ability to plan and prepare routine hot and/cold, nutritionally balanced meals. Include ability to prepare foodstuffs, to open containers, to use kitchen appliances, and to clean up after the meal, including washing, drying and storing dishes and other utensils in meal preparation. Do not consider the ability to plan therapeutic or prescribed meals.

B. Is someone available to prepare meals as needed by the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources (including restaurants and home delivered meals) to prepare meals or supervise meal preparation for the client. Consider whether the resources can be called upon to prepare meals in advance for reheating later.

10. LAUNDRY

A. Is the client able to do his/her laundry?

Assess the client's ability to do laundry including sorting, carrying, loading, unloading, folding, and putting away. Include the use of coins where needed and use of machines and/or sinks. Do not consider the location of the laundry facilities.

B. Is someone available to assist with the performing or supervising the laundry needs of the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of laundry assistance, including washing and/or dry cleaning. If public laundries are used, consider the reliability of others to insert coins, transfer loads, etc.

11. HOUSEWORK

A. Is the client able to do routine housework?

Assess the client's ability to do routine housework. Include sweeping, scrubbing, and vacuuming floors. Include dusting, cleaning up spills, and cleaning sinks, toilets, bathtubs. Minimum hygienic conditions for client's health and safety are required. Do not include laundry, washing and drying dishes or the refusal to do tasks if refusal is unrelated to the impairment.

B. Is someone available to supervise, assist with, or perform routine household tasks for the client as needed to meet minimum health and hygiene standards?

If the client scores at least one (1) in Column A, evaluate the continued availability of resources, including private pay household assistance and family available to maintain the client's living space. When the client lives with others, do not assume the others will clean up for the client. This item measures only those needs related to maintaining the client's living space and is not to measure the maintenance needs of living space occupied by others in the same residence.

12. OUTSIDE HOME

A. Is the client able to get out of his/her home and to essential places outside the home?

Assess the client's ability to get to and from essential places outside the home. Essential places may include the bank, post office, mail box, medical offices, stores, and laundry if nearest available facilities are outside the home. Consider ability to negotiate stairs, streets, porches, sidewalks, entrance and exits of residence, vehicle, and destination in all types of weather. Consider the ability to secure appropriate and available transportation as needed, will increase the score. However, in scoring, do not consider the inability to afford public transportation.

B. Is someone available to assist the client in reaching needed destinations?

If the client scores at least one (1) in Column A, evaluate the continued availability of escort and transportation, or someone to go out on behalf of the client. Consider banking by mail, delivery services, changing laundramats, etc., to make destinations more accessible.

NOTE: When using the MDS-HC, the DON question regarding outside home is incorporated in the

MDS-HC question for transportation.

13. ROUTINE HEALTH CARE

A. Is the client able to follow the directions of physicians, nurses, or therapists, as needed for routine health care?

Assess the client's ability to follow directions from a physician, nurse, or therapist, and to manipulate equipment in the performance of routine health care. Include simple dressings, special diet planning, monitoring of symptoms and vital signs (e.g., blood pressure, pulse, temperature and weight), routine medications, routine posturing and exercise not requiring services or supervision of a physical therapist.

B. Is someone available to carry out or supervise routine medical directions of the client's physician or other health care professionals?

If the client scores at least one (1) in Column A, evaluate the continued availability of someone to remind, supervise or assist the client in complying with routine medical directions. If the assistance needed involves intimate care , and the care giver is inappropriate and/or opposed by the client, consider the assistance unavailable.

14. SPECIAL HEALTH CARE

A. Is the client able to follow directions of physicians, nurses or therapists as needed for specialized health care?

Assess the client's ability to perform or assist in the performance of specialized health care tasks which are prescribed and generally performed by licensed personnel including physicians, nurses, and therapists. Include blood chemistry and urinalysis; complex catheter and ostomy care; complex or non-routine posturing/suctioning; tub feeding; complex dressings and decubitus care; physical, occupational and speech therapy; intravenous care; respiratory therapy; or other prescribed health care provided by a licensed professional. Score "0" for clients who have no specialized health care needs.

B. Is someone available to assist with or provide specialized health care for the client?

If the client scores at least one (1) in Column A, evaluate the continued availability of specially trained resources as necessary to assist with or perform the specialized health care task required by the client.

15. BEING ALONE

A. Can the client be left alone?

Assess the client's ability to be left alone and to recognize, avoid, and respond to danger and/or emergencies. Include the client's ability to evacuate the premises or alert others to the client's need for assistance, if applicable, and to use appropriate judgment regarding personal health and safety.

B. Is someone available to assist or supervise the client when the client cannot be left alone?
If the client scores at least one (1) in Column A, evaluate the continued availability of someone to assist or supervise the client as needed to avoid danger and respond to emergencies. Consider friendly visiting, telephone reassurance, and neighborhood watch programs.

BADL's refer to those activities and behaviors that are the most fundamental self-care activities to perform

and are an indication of whether the person can care for his or her own physical needs.

IADL's are the more complex activities associated with daily life. (They are applications of the BADL's.) Information regarding both BADL and IADL are essential to evaluating whether a person can live independently in the community.

The DON-R Functional Assessment is a unique measure of functional assessment in that it differentiates between impairment in functional capacity and the need for care around a particular functional capacity. Furthermore, it is an ordinal scale with clearly defined meanings for each level of unmet need for care and each functional activity. Because of its ordinal nature, it permits quantification of scores so that changes in scores in subscales for BADL's and IADL's and for Total Impairment represent actual changes in impairment, and changes in scores for unmet need for care in BADL's, IADL's and Total Unmet Need for Care represent actual changes in unmet need for care.

Ask if client has a medical/health problem/diagnosis with functional impairment. Take the following action as appropriate:

1. If answer is "no", inform applicant of CCSP ineligibility and right to appeal. If applicant agrees, complete TS and refer client to other resources as appropriate.

2. If applicant's answer is yes, continue screening process answering each area with appropriate number (0-3).

Some general comments about the DON-R are provided to assist in the completion of the instrument.

The "Case Comments" space to the right of Column B in the functional status section is used to:

- Note special reasons for impairment or unmet need.

- Describe the type of service, caregiver support or assistive devices that decreases the client's unmet need.

- Record the primary care giver's name or other pertinent information.

Column Rules:

Use the following criteria to decide when to stop asking questions for a particular Functional Status item or when to skip Column B:

1. Ask each Functional Status item, starting with Column A, Level of Impairment.

2. If Column A, "level of impairment" is scored "0", score Column B "0".

3. If Column A is scored greater than "0", ask Column B, Unmet Need for Care.

Column A: Level of Impairment

Each one of the BADLs and IADLs needs to be discussed in terms of level of impairment. How the assessor mentions functional impairment is not as important as encouraging the client to report difficulties with the activity. Sample questions could include:

- Are you able to do...?

- How much difficulty do you have in doing...?

NOTE: If an applicant is living in a personal care home or nursing home, determine Impairment Level using Column A of the DON-R.

The objective is to gather sufficient information to determine the most appropriate score.

Answers to these questions should address the degree of unmet need for care if discharge occurs.

Score 0 - Performs or can perform all essential components of the activity, with or without an assistive device, such that:

- No significant impairment of function remains; or
- Activity is not required by the client (IADLs: medication management, routine and special health only); or
- Client may benefit from but does not require verbal or physical assistance.

Score 1 - Performs or can perform most essential components of the activity with or without an assistive device, but some impairment of function remains such that client requires some verbal or physical assistance in some or all components of the activity.

This includes clients who:

- Experience minor, intermittent fatigue in performing the activity; or
- Take longer than would be required for an unimpaired person; or
- Require some verbal prompting to complete the task**Score 2** - Cannot perform most of the essential components of the activity, even with an assistive device, and /or requires a great deal of verbal or physical assistance to accomplish the activity.

This includes clients who:

- Experience frequent fatigue or minor exertion in performing the activity; or
- Take an excessive amount of time to perform the activity; or
- Must perform the activity much more frequently than an unimpaired person; or
- Require frequent verbal prompting to complete the task.

Score 3 - Cannot perform the activity and requires someone else to perform the task, although applicant may be able to assist in small ways; or requires constant verbal or physical assistance.

Column B: Unmet Need for Care

In scoring this column, the idea is both to obtain information from the applicant about his or her

perceptions regarding need for care and to use observational skills to determine the impact on the applicant should care or assistance not be provided, or a caregiver is unable to continue providing care at the current level. The availability of an appropriate caregiver also needs to be assessed.

Assess the degree to which the caregiver feels overwhelmed or burdened by the caregiving situation. The Zarit burden scale or the Caregiver Hassels Scale are formal assessments that may be used to assess caregiver burden.

Questions that might be asked of applicants and caregivers are:

- Do you feel burdened by providing care to your family member or friend?
- How often do you feel this way: frequently (daily), occasionally (weekly), sometimes (monthly), rarely (less than monthly?
- How long will you be willing/able to provide care at the current level?

Questions that might be asked of applicants and caregivers are:

- Can you tell me if you are getting enough help in meeting your needs with...?
- Do you think you need more help with...?

If the applicant is living in a personal care home or nursing home, score the applicant according to the care he would receive if discharged. To determine the future need for care, include the following questions:

a. Who will/would provide care in the home if the person was discharged?
b. How much care will the person need?
c. How much can the person do for him/herself?
d. How often will assistance be provided/available?
e. How long would this plan last?

NOTE: Answers to these questions should address the degree of unmet need for care if discharge occurs. Observe the applicant's mobility, level of clutter, personal appearance, unpaid bills, forgetfulness, etc., to assess the level of risk to health or safety if current levels of assistance are not maintained, or if additional assistance is not added.

Score 0 - The applicant's need for assistance is met to the extent that the applicant is at no risk to health or safety if additional assistance is not acquired; or the applicant has no need for assistance; or additional assistance will not benefit the applicant.

Score 1 - The applicant's need for assistance is met most of the time, or there is minimal risk to the health and safety of the applicant if additional assistance is not acquired.

Score 2 - The applicant's need for assistance is not met most of the time, or there is moderate risk to the health and safety of the applicant if additional assistance is not acquired.

Score 3 - The applicant's need for assistance is seldom or never met; or there is severe risk to the health:

and safety of the applicant that would require acute medical intervention if additional assistance is not acquired.

Comments - Ask applicant "If you don't get CCSP services, what will happen" and record the answer in applicant's own words.

Distribution: Export the file from CHAT to the care coordinator for initial assessment

NOTICE OF STATUS OF REQUEST FOR SERVICES FROM THE COMMUNITY CARE SERVICES PROGRAM

To: _____

_____

_____

Date of Request: _____

Based on your telephone screening assessment, you have been determined eligible for the Community Care Services Program (CCSP). We have added your name to the list of individuals waiting to be served through the CCSP.

When funds become available, a nurse will contact you to make an appointment to visit you to work with you in developing a service plan that meets your needs. **Your name will remain on the waiting list until otherwise notified.**

If you have questions about this information or your situation changes, please contact the person listed below.

_____ _____( )_____

Screening Specialist Telephone

_____ _____

Area Agency on Aging Fax

_____

Address

_____

_____

Date

Rev. 08-08-01

Instructions
Community Care Services Program

NOTICE OF STATUS OF REQUEST FOR SERVICES FROM THE COMMUNITY CARE SERVICES PROGRAM

Purpose: The Notice of Status form is used to notify applicants of their CCSP eligibility and placement on the waiting list.

Who completes/When completed: The screening specialist completes the form when notifying an applicant of the waiting list status.

Instructions:
Enter the applicant's name and address.

Enter the date of the applicant's request or the referral for CCSP.

Enter the name and phone number of the screening specialist.

Enter the name, address, fax number of the Area Agency on Aging and the date the letter is being mailed.

Distribution: The screening specialist completes this form and sends it to the applicant or representative. Indicate in the case notes that the form was sent to the applicant.

Revised 8/8/01

YOUR LETTERHEAD HERE

Date _____

To: _____

Client Name : _____

DOB _____

SS# _____

1. Documentation of client's symptoms or observations that require medical assessment and diagnosis.

_____

_____

_____

2. Reported Medical Problems

_____ _____

_____ _____

_____ _____

_____ _____

3. Indicate Mental Retardation/Mental Health diagnosis

_____

We have assessed/reassessed this client to assess for services through the Community Care Services Program (CCSP). CCSP is a waivered service under Medicaid that provides services in the community for the client who, otherwise, would qualify for nursing home placement. Attached you will find the client's problems and needs identified. Please review these documents.

Please sign and return forms to our office as soon as possible to allow us to arrange/continue to arrange for delivery of services.

Respectfully,

_____
Care Coordinator

Original PHYSICIAN'S or NP SIGNATURE REQUIRED FOR APPROVAL of Level of Care
Please return no Later than _____

Instructions
Community Care Services Program

COVER LETTER FOR LEVEL OF CARE (LOC) FORM

Purpose: The intent of the letter is to identify medical problems, signs and symptoms, and observations to assist the physician in the diagnosis.

Who Completes/When Completed: The care coordinator completes the cover letter and attaches it to the Level of Care (LOC) form and care plan sent to the physician at the time of the initial assessment or reassessment of the client.

Instructions:

Date: Enter date care coordinator completes LOC cover letter.

To: Name of primary physician responsible for medical oversight.

Client Name: Enter name as it is written on Level of Care form.

Date of Birth: Enter same DOB as is written on LOC form.

Social Security Number: Enter client Social Security number.

1. Enter any pertinent information required to meet the Intermediate Level of Care. This area applies to sign/symptoms/observations the physician may need to assess in the absence of a diagnoses. An example may be short-term memory loss with resulting ADL deficits

2. Enter diagnosis included on the referral form and those stated by the client and/or family. The priority of diagnosis listing should be reflective of those diseases that result in deficits that meet the criteria of the intermediate LOC.

3. Enter any known or stated mental health and or mental retardation diagnosis.

The care coordinator signs the form.

Enter date the signed form is required to be returned to meet the SOP.